Rhode Island Health Care Quality Performance (HCQP) Program

10th Annual Report to the General Assembly

R.I.G.L. 23-17.17-5, Fiscal Year 2008

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www.health.ri.gov/chic/performance/index.php

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I. Executive Summary

Over the past 10 years, the Department of Health (HEALTH) has worked with healthcare providers and other stakeholders to implement a healthcare quality public reporting system for all licensed healthcare facilities in the State. Initially, the Health Care Quality Performance (HCQP) Program reported data for home health agencies, hospitals, and nursing homes. During Fiscal Year (FY) 2008 (July 1, 2007 through June 30, 2008), the Program added two new stakeholder groups to identify ways to report (1) elective surgical procedure volumes and (2) health information technology (HIT) adoption, both at the physician level. These activities reflect the Program's response to a 2006 amendment to the legislation that expanded the public reporting mandate to include physicians.

During FY 2008, the Program completed the following public reporting activities:

Healthcare Setting/Task	FY 2007 Activity
Elective Procedures	✓ Convened a Subcommittee ✓ Identified elective outpatient procedures for reporting
Home Health Agencies	✓ Updated the clinical quality measure reports quarterly ✓ Collected and reported patient satisfaction
Hospitals	✓ Updated the clinical quality measure reports quarterly
Nursing Homes	✓ Updated the clinical quality measure reports quarterly ✓ Collected and reported resident and family satisfaction
Physician HIT Adoption	✓ Convened a Workgroup ✓ Vetted a survey instrument and measures ✓ Collected pilot data from all licensed physicians in the first-ever statewide data collection effort

The above activities were limited by the State's fiscal crisis. The Program's contractor budget was cut approximately 50% in December 2007 and a stop work order was issued in May 2008. As a result of the first budget cut, some Program activities were suspended and others slowed; after the stop work order, all Program meetings and reports were halted until FY 2009.

As of July 1, 2008, the Program is fully funded. FY 2009 Program goals (described in this report) include reinstating the Elective Procedures Subcommittee and Physician HIT Adoption Workgroup, continuing the FY 2008 data collection efforts, and reporting hospital satisfaction and hospital-acquired infections for Rhode Island hospitals.

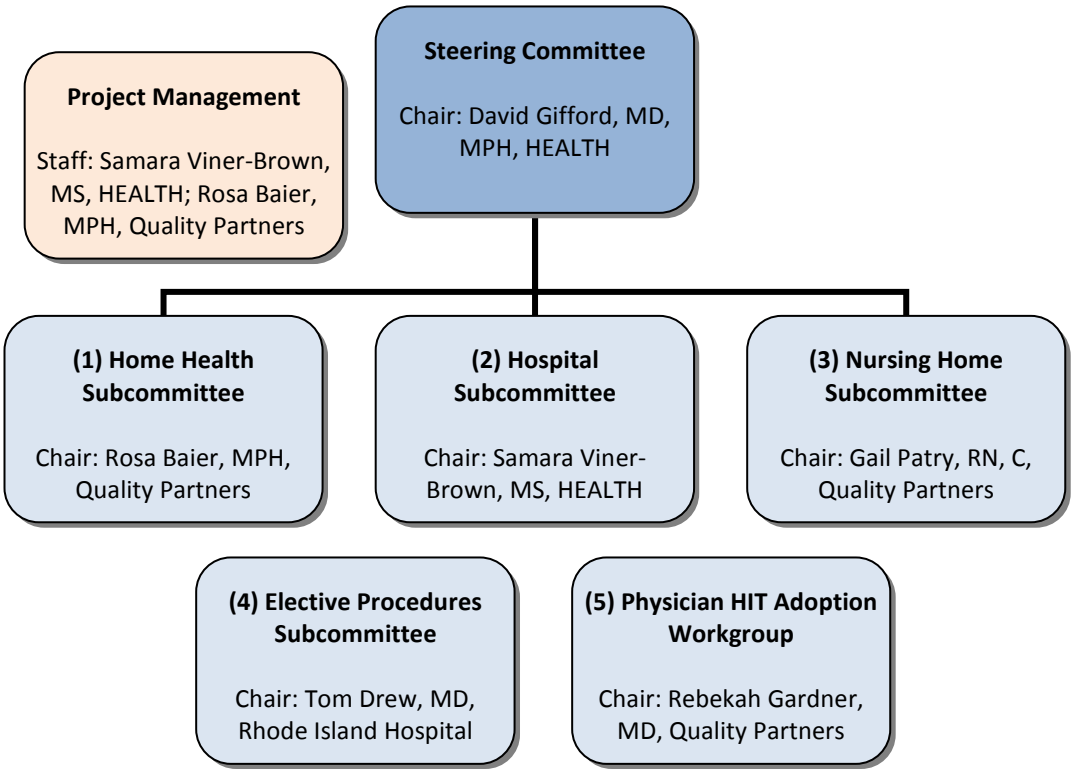
II. Program Overview

In 1998, the State of Rhode Island mandated that HEALTH develop a healthcare quality public reporting system for all licensed healthcare facilities.[1] With the Health Care Quality Performance (HCQP) Program's mandate, licensed healthcare facilities were required to report clinical outcomes and patient satisfaction through HEALTH's website:

http://www.health.ri.gov/chic/performance

The Program is governed by a 19-member Steering Committee, Chaired by the Director of HEALTH and managed by HEALTH and its contractor, Quality Partners of Rhode Island (**Figure 1**). Each setting has a public stakeholder group that vets proposed measure(s) and provides recommendations on the measures, process, and report format to the Steering Committee.

Figure 1: HCQP Program Organizational Structure (September 2008)



Over the past 10 years, HEALTH has worked with healthcare providers and other stakeholders to report data for home health agencies, hospitals, and nursing homes. During FY 2008, the Program added two new stakeholder groups to identify ways to report additional measures: (1) elective surgical procedure volumes, and (2) health information technology (HIT) adoption, both at the physician level. These

[1] Chapter 23-17.17, Health Care Quality Program, Index of Sections [Online]. Available: http://www.rilin.state.ri.us/Statutes/TITLE23/23-17.17/INDEX.HTM, 02 Sept 2008.

activities reflect the Program's response to a 2006 amendment to the legislation that expanded the public reporting mandate to include physicians.

III. FY 2007 Reporting Activity[2]

The FY 2007 work of each Subcommittee is described below.

A. Elective Procedures

The Elective Procedures Subcommittee was formed at the end of FY 2007 to recommend **surgical volume measures** for use by consumers and their referring physicians. The Subcommittee was active between June and December 2007, during which time it:

- ✓ Calculated physician- and hospital-level data reports for outpatient surgical procedures;
- ✓ Used these reports to identify the most common procedures in Rhode Island;
- ✓ Performed an environmental scan to identify published literature supporting a volume-quality link for each of the procedures; and
- ✓ Evaluated the strength of the volume-quality evidence base for each procedure.

The Subcommittee's membership included surgeons, primary care physicians, representatives from academic and community hospitals, and the Hospital Association of Rhode Island (HARI). The Subcommittee's goal was to generate a populated data report by January 2008; however, this work was suspended in December 2007 as a result of the Program's budget cuts. The Program plans to restart the Elective Procedures Subcommittee in FY 2009.

B. Home Health Agencies

The Program reported both clinical outcomes and patient satisfaction in FY 2008:

http://www.health.ri.gov/chic/performance/homehealth/index.php

The **clinical outcomes** for Medicare-certified home health agencies are presented in a "diamond report" that is updated quarterly to reflect an annualized average. The report includes 11 measures publicly reported by the Centers for Medicare & Medicaid Services (CMS) for Medicare-certified home health agencies in Rhode Island.[3] Agencies' clinical measure scores are classified into three categories (below average, average, above average) based on the proximity of their score to the national average. If the score's 90% confidence interval overlaps the national average, the agency is categorized as average (◆◆) for that measure; if the confidence interval does not overlap the national average, the agency is classified as below average (◆) or above average (◆◆◆).

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[2] Note: In FY 2007, the State's fiscal crisis affected the Program substantially. The Program's contractor budget was cut approximately 50% in December 2007 and a stop work order was issued in May 2008. As a result of the first budget cut, the Program's Elective Procedures Subcommittee and Physician HIT Adoption Workgroup were suspended; the Physician HIT Survey was later funded by Blue Cross Blue Shield of Rhode Island (BCBSRI). The work of the remaining Subcommittees was simultaneously limited to essential, time-sensitive tasks only. After the stop work order, all Program meetings and reports were halted until FY 2008 began on July 1, 2008. As of September 2008, all activities are fully funded.

[3] Centers for Medicare & Medicaid Services (CMS). Home Health Compare [Online]. Available: http://www.medicare.gov/HHCompare/, 2 Sept 2008.

After collecting a round of pilot data in FY 2007, all of Rhode Island's home health agencies also collected and reported **patient satisfaction** data in FY 2008. The agencies used a survey vendor named Press Ganey Associates[4] and collected data from September to November 2007. The surveys included data for seven domains of patient satisfaction and were customized for skilled and non-skilled agencies. They were sent to patients on service for 30 days or more or discharged during the survey period and for up to 30 days before the survey period started.

Prior to seeing their agencies' individual results, Subcommittee participants created a one-page report format that included agency information, survey results, and clinical quality measures (for Medicare-certified agencies). As with the clinical measures, satisfaction data are classified into three categories (below average, average, above average). Data are classified using a 95% confidence interval and the state mean. If the score's 95% confidence interval overlaps the state average, the agency is categorized as average; if the confidence interval does not overlap the state average, the agency is classified as below average or above average.

After an initial delay caused by the state's budget crisis, the agencies' satisfaction data reports were released in May 2008. HEALTH's press release provides additional details about the results:

http://www.health.ri.gov/media/080529a.php

Notably, Rhode Island was the first state in the nation to report home health patient satisfaction.

C. Hospitals

The Program reported clinical outcomes and staffing plans in FY 2008:

http://www.health.ri.gov/chic/performance/hospitals.php

The **clinical outcomes** for Medicare-certified hospitals are presented in a bar graph format that is updated quarterly. The report includes three clinical measures publicly reported by CMS for Medicare-certified Rhode Island hospitals.[5] Hospitals' clinical measure scores are presented as percentages and compared to state and national averages.

Staffing plans for each of Rhode Island's hospitals are submitted annually to HEALTH and posted on the Program's website. These prospective reports indicate how each hospital will staff their units based on estimates of the future census for each unit.

Although these measures have not yet been publicly reported, the Hospital Subcommittee recommended two **pressure ulcer process measures** (or "nurse sensitive measures") during FY 2008. The measures come from the Institute for Healthcare Improvement's (IHI's) *5 Million Lives* campaign.[6] The hospitals used IHI's existing infrastructure to pilot data collection for these measures between

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[4] Press Ganey Associates [Online]. Available: https://www.pressganey.com/, 2 Sept 2008.

[5] Centers for Medicare & Medicaid Services (CMS). Hospital Compare [Online]. Available: http://www.hospitalcompare.hhs.gov/Hospital/, 2 Sept 2008.

[6] Institute for Healthcare Improvement (IHI). 5 Million Lives campaign [Online]. Available: http://www.ihi.org/IHI/Programs/Campaign/, 2 Sept 2008.

October 2007 and July 2008. The facility-level pilot results are confidential, but the Program shared aggregate results with the Hospital Subcommittee and Steering Committee (**Appendix A**). Hospitals will collect these data for public reporting during FY 2009.

D. Nursing Homes

The Program reported clinical outcomes and resident and family satisfaction in FY 2008:

http://www.health.ri.gov/chic/performance/nursinghome.php

The **clinical outcomes** for Medicare-certified nursing homes are presented in a "diamond report" that is updated quarterly to reflect an annualized average. The report includes 19 measures publicly reported by the Centers for Medicare & Medicaid Services (CMS) for Medicare-certified nursing homes in Rhode Island.[7] Nursing homes' clinical measure scores are classified into three categories (bottom 25%, middle 50%, top 25%) based on the state's 25th and 75th percentile cut-points. If the score's 50% Confidence interval overlaps the 25th or 75th percentile, the nursing home is categorized in the middle 50% (◆◆) for that measure; if the Confidence interval does not overlap the 25th or 75th percentile, the nursing home is classified as the bottom 25% (◆) or top 25% (◆◆◆).

Rhode Island's nursing homes collected and reported **resident and family satisfaction** data for the second time during FY 2007. This was the nursing homes' first time using the survey vendor My InnerView;[8] for the pilot and first rounds of data collection, they used a company named Vital Research.[9] The nursing homes collected data in October and November 2007. The surveys include data for four domains of patient satisfaction and were sent to all cognitively intact long-stay (100+ days) residents and to family members for cognitively impaired residents. The satisfaction data were classified into three categories (bottom 25%, middle 50%, top 25%) using the same classification strategy as for the clinical measures (above).

After an initial delay caused by the state's budget crisis, the nursing homes' satisfaction data reports were released in April 2008. HEALTH's press release provides additional details about the results:

http://www.health.ri.gov/media/080430a.php

The press release highlights the fact that Rhode Island nursing homes, on average, outperformed nursing homes nationwide that used the same survey in 2007.

E. Physician HIT Adoption

The Physician HIT Adoption Workgroup was formed at the end of FY 2007 to recommend and pilot **measures of HIT adoption** to be reported at the physician- and/or practice-level. Rather than form a dedicated Subcommittee, as is customary in the Program, this Workgroup leveraged existing physician and stakeholder groups in the community. In particular, the Rhode Island Quality Institute's Clinical IT

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[7] Centers for Medicare & Medicaid Services (CMS). Home Health Compare [Online]. Available: http://www.medicare.gov/NHCompare/, 2 Sept 2008.

[8] My InnerView, Inc. [Online]. Available: http://www.myinnerview.com/, 2 Sept 2008.

[9] Vital Research, Inc. [Online]. Available: http://www.vitalresearch.com/, 2 Sept 2008.

Leadership Council, which includes physician representation, provided ongoing input. The use of a Workgroup instead of a Subcommittee was intended to maximize efficiency for interested parties, rather than schedule additional meetings.

The Workgroup was active between May and December 2007, during which time it:

- ✓ Conducted an informal scan of available survey instruments and measures;
- ✓ Worked with stakeholders to create four measures of physician HIT adoption;
- ✓ Developed and vetted a survey instrument; and
- ✓ Prepared to disseminate the survey electronically to all licensed physicians via SurveyMonkey.

In December 2007, the Workgroup's funding was eliminated. At that time, the Program's contractor, Quality Partners, received funding from Blue Cross Blue Shield of Rhode Island (BCBSRI) to implement and analyze the survey.[10] Between January and June 2008, Quality Partners:

- ✓ Disseminated the survey, including mailed notifications, email links, and email reminders;
- ✓ Created and mailed physician-level data feedback reports; and
- ✓ Calculated and shared aggregate results with the stakeholders and Steering Committee (**Appendix B**).

The Program plans to restart the Physician HIT Adoption Workgroup in FY 2009.

IV. FY 2008 Program Goals

In FY 2009, which began July 1, 2008, the Program anticipates activities that include the following:

Healthcare Setting/Task	FY 2008 Activity
Elective Procedures	✓ Reconvene the Subcommittee ✓ Calculate pilot volume-quality reports for the selected outpatient surgical procedures and share results with individual providers
Home Health Agencies	✓ Continue to convene the Subcommittee ✓ Update the clinical quality measure reports quarterly ✓ Prepare for the second round of satisfaction data collection
Hospitals	✓ Continue to convene the Subcommittee ✓ Update the clinical quality measure reports quarterly ✓ Collect and report pressure ulcer process measure data ✓ Collect pilot pressure ulcer incidence data and share results with individual hospitals ✓ After pilot, collect and report pressure ulcer incidence data publicly ✓ Report the newly-available satisfaction data from the Centers for

[10] This partnership benefited BCBSRI, which determined its primary care physicians' eligibility for an HIT fee increase based on their survey responses. Because the pilot results were confidential, BCBSRI did not have access to physician-level data. Quality Partners mailed each physician a data feedback report, and the physicians submitted their reports to directly BCBSRI.

Healthcare Setting/Task	FY 2008 Activity
	Medicare & Medicaid Services' (CMS') Hospital Compare website
Hospitals (Cont'd)	✓ Convene a Hospital-Acquired Infections Workgroup ✓ Identify and report hospital-acquired infections
Nursing Homes	✓ Continue to convene the Subcommittee ✓ Update the clinical quality measure reports quarterly ✓ Collect and report the third round of satisfaction data
Physician HIT Adoption	✓ Reconvene the Workgroup ✓ Validate the pilot results and proposed measures ✓ Revise and re-administer the survey instrument ✓ Publicly report the measures

As with previous years, Program leadership will work with the Steering Committee and the Director of HEALTH to prioritize the above activities within the Program's available resources (e.g., staff time, budget) and ensure that they align with local healthcare priorities.

V. Project Management

Figure 1 (page 3) presents the Program's Organizational Structure, including the Steering Committee and Subcommittees and the project management. Further details about the Steering Committee and project management are below, along with financial information.

A. Steering Committee Membership

The 19-member Steering Committee is legislatively mandated to include:

> "…one member of the house of representatives, to be appointed by the speaker; one member of the senate, to be appointed by the president of the senate; the director or director's designee of the department of human services; the director or the director's designee of the department of mental health, retardation, and hospitals; the director or the director's designee of the department of elderly affairs; and thirteen (13) members to be appointed by the director of the department of health to include persons representing Rhode Island licensed hospitals and other licensed facilities/providers, the medical and nursing professions, the business community, organized labor, consumers, and health insurers and health plans and other parties committed to health care quality."[11]

Current Steering Committee membership is detailed below:

Organization	Representative (Sept. 2008)
1. Alliance for Better Long-Term Care	Donna Lonschein, RN
2. BCBSRI	Sharon Pugsley, BSN
3. The Claflin Company	Ted Almon

[11] Chapter 23-17.17, Health Care Quality Program, Index of Sections [Online]. Available: http://www.rilin.state.ri.us/Statutes/TITLE23/23-17.17/INDEX.HTM, 02 Sept 2008.

Organization	Representative (Sept. 2008)
4. Department of Elderly Affairs	Corrine Russo, MSW
5. Department of Human Services	Sharon Reinere
6. HEALTH	David Gifford, MD, MPH
7. Department of Mental Health, Retardation, and Hospitals	Louis Pugliese
8. Rhode Island Association of Facilities & Services for the Aged (RIAFSA)	James Nyberg
9. Rhode Island Health Care Association	Virginia Burke, Esq.
10. Rhode Island Medical Society	Arthur Frazzano, MD
11. Rhode Island Partnership for Home Care	Alan Tavares
12. Rhode Island State Nurses Association	Donna Policastro, NP, RCN
13. Hospital Association of Rhode Island	Gina Rocha, RN, MPH
14. State Senate	Rhoda E. Perry
15. United Health Care of New England	Neal Galinko, MD, MS, FACP
16. United Nurses & Allied Professionals	Linda McDonald, RN

There are currently three vacant seats on the Steering Committee that should be filled by: (1) the Rhode Island Health Center Association, (2) the Rhode Island House of Representatives, and (3) a designee of the Director's choice. The Program is working to fill these seats.

B. Project Staffing

The Program is part of HEALTH's Center for Health Data and Analysis and is run through a contract with Quality Partners of Rhode Island. HCQP project leadership include:

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C. Budget

The Program's FY 2007 budget was substantially affected by the State's budget crisis. As described previously, the Program's contractor budget was cut approximately 50% in December 2007 and a stop work order was issued in May 2008. As a result of the first budget cut, the Program's Elective Procedures Subcommittee and Physician HIT Adoption Workgroup were suspended; the Physician HIT Survey was later funded by Blue Cross Blue Shield of Rhode Island (BCBSRI). The work of the remaining Subcommittees was simultaneously limited to essential, time-sensitive tasks only. After the stop work order, all Program meetings and reports were halted until FY 2009 began on July 1, 2008. This is reflected in the expenditures outlined below.

FY 2007 Expenditures	FY 2008 Expenditures
$216,132	$152,471

As of September 2008, all activities are fully funded.

D. Public Information

The HCQP Program public reports, referenced above, are posted online at the Program's website:

www.health.ri.gov/chic/performance

All Steering Committee and Subcommittee meetings are open to the public, and Steering Committee minutes are posted on the Rhode Island Secretary of State's open meetings website:

www.sec.state.ri.us/pubinfo/openmeetings

Anyone interested in receiving email notices of upcoming meetings should contact Program staff to subscribe to email distribution lists for the Steering Committee and/or Subcommittees.

VI. Summary

This Annual Report describes the FY 2008 activities for the HCQP Program. Although the above activities were limited by the State's fiscal crisis, the Program's full funding was reinstated on July 1, 2008. FY 2009 Program goals, described above, include reinstating the Elective Procedures Subcommittee and Physician HIT Adoption Workgroup, continuing the FY 2008 data collection efforts, and reporting hospital satisfaction and hospital-acquired infections for Rhode Island hospitals.

Appendices

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PRESSURE ULCER PROCESS MEASURES

Aggregate Pilot Results, 09/10/08

The following data are pilot results from the Department of Health's (HEALTH's) work with the 11 acute care hospitals to collect pressure ulcer process measure data for two Institute for Healthcare Improvement (IHI) *5 Million Lives Campaign* measures:

1. The percent of patients receiving pressure ulcer admission assessment; and
2. The percent of patients receiving daily pressure ulcer risk reassessment.

Each hospital collected and submitted data for a day of their choice in a week selected by the Hospital Subcommittee. The below results reflect all four quarters of the pilot:

	Admission Assessment	Daily Reassessment
Quarter	n (%)	
Quarter 1 (October 2007)	1,137 (89.2%)	915 (87.1%)
Quarter 2 (January 2008)	1,034 (90.3%)	918 (87.9%)
Quarter 3 (April 2008)	1,041 (95.1%)	928 (93.6%)
Quarter 4 (July 2008)	1,094 (92.2%)	1,029 (95.1%)
Annual average	**4,306 (91.7%)**	**3,790 (90.9%)**

Department of Health

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PHYSICIAN HIT SURVEY

Results, 04/30/08

The following data are summary results from the Department of Health's (HEALTH's) physician health information technology (HIT) survey.

Survey Administration

- The survey was live on the SurveyMonkey Web site from January 2, 2008 until March 2, 2008.
- Mailed notifications were sent to 2,125 physicians in the HEALTH licensure database who indicated that they were in active practice. Email notifications were also sent to those with email addresses.
- HEALTH sent email reminders one and two weeks before the survey closed. Reminders were targeted at non-respondents, although some respondents may have received a reminder if they did not access the survey via a link emailed directly to them.
- Respondents received data feedback reports by March 31, 2008.

Respondent Characteristics

- After eliminating duplicate responses, there were 970 respondents with Rhode Island licenses in active practice in Rhode Island, Massachusetts, or Connecticut (45.6%). (Duplicate, out-of-state physician, and non-physician respondents are excluded from aggregate analyses.)
- The majority of respondents provided direct patient care at least 20 hours a week (n=806, 83.1%).
- Approximately half of respondents were in primary care (family medicine, internal medicine, pediatrics, or primary care; n=488, 50.3%).

Respondents Using HIT

- Four measures related to electronic medical record (EMR) and e-prescribing adoption have been proposed for public reporting:

Measure	Average Response (N=970)
- EMR Components In Main Practice, % Yes	54.3%
- e-Prescribing in Main Practice, % Yes	37.6%
- Use of Clinical Functionality, 33 points*	17.8 points
- Use of Advanced Clinical Functionality, 27 points†	10.7 points

* Based on respondents' answers to 11 questions that ask about use of specific EMR functionalities. Respondents receive 0-3 points per question based on their frequency of use of the functionality.

† Based on respondents' answers to 9 questions that ask about use of specific EMR functionalities. Respondents receive 0-3 points per question based on their frequency of use of the functionality.

Respondents Using HIT (*Cont'd*)

- Among the 527 respondents who report having EMRs in their main practices:
  - The majority implemented EMRs in 2005 or later (n=242, 52.4%). Half either did *not* have a Certification Commission for Healthcare Information Technology- (CCHIT-) certified EMR (n=27, 5.1%) or did not know if their EMR was CCHIT-certified (n=242, 45.9%).
  - Nearly one in four (n=119, 22.6%) provided vendor information that identified their EMR as something less than a fully functional EMR: e-prescribing software, a homegrown system, a practice management system, a specialized EMR, or some other type of EMR.
  - Approximately one in three respondents (n=156, 29.6%) reported that their practice received financial incentives to implement their EMR. The remainder did not receive financial incentives at their practice (n=188, 35.7%) or did not know if they did (n=150, 28.5%).
- Among the 365 respondents who report using e-prescribing:
  - The majority said they transmitted prescriptions electronically at least 60% of the time (n=220, 60.3%).
  - The e-prescribing estimate has been 'validated' using HEALTH data that tracks the total number of physicians using SureScripts. By dividing this count by 2,125—the total number of physicians providing direct patient care in the licensure database—HEALTH's monthly estimates from January 2008 through March 2008 range from 35.7% to 38.8%. These estimates that are close to the survey response average of 37.6% and help validate this estimate.

Respondents Not Using EMRs

- Of the 443 respondents not using EMRs, approximately one-third planned to implement an EMR within one year (n=58, 13.1%) or in one to two years (n=76, 17.2%). However, the majority did not know when their practice plans to implement an EMR or did not have plans to do so (n=241, 54.4%).
- The top four reported 'major' barriers to EMR adoption were: (1) start-up financial costs (n=174, 39.4%); (2) ongoing financial costs (n=166, 37.6%); (3) lack of uniform industry standards (n=101, 22.9%); and (4) training and productivity loss (n=100, 22.6%).

Limitations

- Responses may be skewed towards those using HIT, in part because of the BCBSRI requirement to complete the survey in order to qualify for its primary care physician fee increase.